Case number: 2600590/2022

EMPLOYMENT TRIBUNALS

Claimant: Ms L Mulligan

Respondent: Greenbrook Healthcare (Hounslow) Limited

Heard: at Nottingham **On:** 12 January 2023

Before: Employment Judge Clark (sitting alone)

Representation

Claimant: Ms Halsall of Counsel
Respondent: Ms C Mallin-Martin of Counsel

RESERVED JUDGMENT

1. By consent, at all material times the claimant was a disabled person by virtue of her impairment of hypertension within the meaning of s.6 of the Equality Act 2010.

2. The claimant was not a disabled person by virtue of the impairment of arteriosclerosis.

3. The claimant was not a disabled person at the material time by virtue of the impairment of heart failure / cardiomyopathy, but was a person with a past disability arising from that impairment.

4. At all material times the claimant was a disabled person by virtue of her impairment asthma.

REASONS

1. Introduction

1.1 This is a preliminary hearing in public to determine whether the Ms Mulligan was disabled within the legal definition in section 6 of the Equality Act 2010. There is no dispute that the claimant was disabled at all material times as a result of the physical impairment of hypertension. Equally, Ms Mulligan no longer relies on other physical impairments relating to her neck, shoulders, post-menopausal bleeding and stomach ulcers. What is disputed is whether three other impairments also mean she satisfies the legal definition of disability at the relevant time. They are arteriosclerosis, asthma and cardiomyopathy or “a history of heart failure”.

1.2 At the outset I explored the extent to which these additional impairments were relevant to issues in the case. I also explained that the approach to determining the section 6 definition was based on a social model of disability, as opposed to a medical model. I was concerned that taking too narrow a focus on separate clinical diagnoses can be unproductive as the clinical label of the impairment is often the least significant element of the section 6 analysis. That is so particularly as, putting asthma to one side, there is potentially some interrelationship between the remaining three impairments. All three could be described more generally as a physical impairment of the cardio-vascular system. Nevertheless, I was told by both parties that it was important to resolve these allegations of disability in the context of the claim and was invited to approach the question in the way that the contentions have been put by the claimant and defended by the respondent.

1.3 For the purpose of this assessment, the relevant period is agreed to be between May 2020 and 9 April 2022.

2. Evidence

2.1 I have the disability disclosure bundle including Ms Mulligan's disability impact statement which she adopted on oath. I received a bundle of documents running to 276 pages. The bundle contains a summary extract of her medical records.

2.2 I refused an application by the claimant to adduce additional oral evidence in chief going to deduced effects. I refused it on the ground that there was no reasonable explanation why that was not covered in her evidence; it was not a new issue that had arisen unexpectedly; it was raised only today on the day of the hearing of the issue; the claimant had been represented throughout; the case management orders were extremely clear and informative on the likely further evidence needed and permitting it would inevitably lead to the need for further instructions and advice and delay.

2.3 Both parties made brief oral closing submissions speaking to written skeleton arguments.

3. Law

3.1 The law is found principally in Section 6 and schedule 1 of the Equality Act 2010 ("the Act") and, by section 6(5), includes consideration of the 2011 guidance on matters to be taken into account in determining questions relating to the definition of disability ("the guidance"). Section 6 of the Act states, so far as is relevant:

> ***"(1) A person (P) has a disability if -***
>
> ***(a) P has a physical or mental impairment, and***
>
> ***(b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities."***

3.2 It remains good practice to state conclusions separately on the questions of impairment, adverse effect, substantiality and long-term nature: (*Goodwin v Patent Office [1999] ICR 302*) however, in reaching those conclusions the tribunal should not proceed by

rigid consecutive stages. A purposive approach should be taken without losing site of the overall condition.

3.3 Impairment is to be given its ordinary meaning without more. Where there is more than one impairment, the totality of their effects may need to be considered when assessing the linked concepts of substantial and long-term (see the guidance at paragraph B6, *Ginn v Tesco Stores Limited [2005] ALL ER (D) 259(Oct)* and *Patel v Oldham Metropolitan Borough Council [2010] ICR 603)*. Where the presence of a disputed impairment is not clear, it may be left until after the analysis of long-term substantial effects. As Underhill P said at paragraph 42 of *J v DLA Piper UK LLP [2010] ICR 1052*: -

> ***Specifically, in cases where there may be a dispute about the existence of an impairment it will make sense, for the reasons given in para 38 above, to start by making findings about whether the claimant's ability to carry out normal day-to-day activities is adversely affected (on a long-term basis), and to consider the question of impairment in the light of those findings."***

3.4 Adopting that approach, in *Herry v Dudley Metropolitan Borough Council UKEAT/0100/16/LA* HHJ Richardson observed how: -

> ***"an Employment Tribunal might start with the question whether the Claimant's ability to carry out normal day-to-day activities had been impaired. This would assist it to resolve, in difficult cases, whether an impairment existed".***

3.5 By section 212(1) and paragraph B1 of the guidance: -

> ***"substantial" means more than minor or trivial***

3.6 This is a relatively low threshold for a claimant to establish. Substantial may be considered in respect of different times, different activities, the way an activity is done and having regard to modifications which are reasonable for the claimant to make but based on what the deduced effect is, that is what it would be excluding the effect of treatment. There must be clear evidence on what the deduced effect would be (*Woodrup v London Borough of Southwark [2003] IRLR 111*). Although a low threshold, the claimant carries the burden of showing it.

3.7 The focus in an assessment of disability should be on what a claimant cannot do or can only do with difficulty, and not on what they can do. I am required to look at the whole picture and it is not a question of balancing what can be done against what cannot. If the claimant's ability to carry out some aspect of normal day to day activities is substantially adversely affected, then they are disabled notwithstanding their ability in a range of other activities.

3.8 Long-term and substantial go hand in hand; they each qualify the other and the adverse effect within the statutory test (*Cruickshank v VAW Motorcast Ltd [2002] ICR 729 EAT*). The effects need not be the same over the period.

3.9 By Schedule 1 of the Act, further provisions define whether a person is disabled. Specifically, paragraph 2 provides: -

> ***"2. Long-term effects***
>
> ***(1) The effect of an impairment is long-term if—***

(a)it has lasted for at least 12 months,

(b)it is likely to last for at least 12 months, or

(c)it is likely to last for the rest of the life of the person affected.

(2) If an impairment ceases to have a substantial adverse effect on a person's ability to carry out normal day-to-day activities, it is to be treated as continuing to have that effect if that effect is likely to recur.

(3) For the purposes of sub-paragraph (2), the likelihood of an effect recurring is to be disregarded in such circumstances as may be prescribed.

(4) Regulations may prescribe circumstances in which, despite sub-paragraph (1), an effect is to be treated as being, or as not being, long-term.

3.10 Where it is necessary to project forward to determine whether an impairment is long-term (see paragraph 1(b)) the tribunal must consider the evidence as it stood at that point in time and address the question whether it was likely to last the necessary period. In that regard, whether something is "likely" under the act is to be interpreted as "could well happen (see *SCA Packaging Ltd v Boyle [2009] ICR 1056 HL* and paragraph C3 of the guidance)

3.11 As for what is relevant to the determination of this question, a broad view is to be taken of the symptoms and consequences of the disability as they appeared during the material time. (*Cruickshank***)**.

3.12 I have been referred to *Carl Room Restaurants Limited T/A Macdonald's Restaurants Limited v Da Silva Primaz EAT 2020-278/JOJ* for the proposition that when applying section 6 there has to be an evidential basis for concluding there is an objective causal link between the adverse effect and the impairment. A belief on the part of the claimant that there is a link is not enough. I was also provided with a copy of *Taylor v Ladbrokes Betting and Gaming Limited UKEAT/0353/15/DA***,** a case concerning the assessment for progressive conditions although in the event no specific submissions drew on it.

4. Facts

Facts

4.1 By way of background to Ms Mulligan's health history, there is no dispute that she was diagnosed with hypertension in the early 1990's and since then has been prescribed with cholesterol lowering medication. There is evidence that without medication for that condition, Ms Mulligan could potentially have a stroke which could result in paralysis, physical disability or death. There is evidence that the hypertension leaves her extremely tired, sometimes experiencing mental fog. She sometimes experiences nosebleeds, headaches and focal migraines. She experienced shortness of breath and swelling in her feet and ankles. All of those consequences have an effect on her ability to perform day to day domestic chores for which she requires help that is provided now by her adult children and previously by a paid cleaner. Ms Mulligan limits the extent to which she attempts housework as if she does too much she knows it will adversely affect her abilities the following day, including being able to get out of bed.

4.2 Ms Mulligan also relies on a history of heart failure or cardiomyopathy. She now steps back from the description of heart failure, although makes a fair point that it is a term to describe any defect in the heart's optimal functioning and is not synonymous with cardiac

arrest. That aside, there is no dispute that between 2003 and 2005 she was diagnosed with a non-dilated mild globally hypokinetic left ventricle, with mild systolic dysfunction and left bundle branch block. She showed an abnormal echocardiogram and was found to have a mild form of cardiomyopathy which continued to improve over that period. By April 2005, the echocardiogram was described as entirely normal. There are various references to further echocardiograms over the following years which return results of 'stable and asymptomatic', 'effectively normal' and 'no significant abnormality seen in the heart'. Ms Mulligan herself describes the cardiomyopathy as "now being resolved". She continues to take Losarta, the purpose of which I find is not to treat any effects of a condition, but as a precaution to support and protect her health in the event that the condition should spontaneously return. There clearly was, and continues to be, a clinical assessment that the chance that the condition could spontaneously return and the potential consequences if it did justify the continued use of the drug.

4.3 At the material time for this case, however, I cannot see that it is said to be causative of any substantial adverse effects on her ability to carry out day to day activities. Indeed, it is accepted that it has resolved as a condition, her "muscle is better" and Ms Mulligan agreed that it did not cause any adverse effect during the relevant period. At the time it was first diagnosed, however, I accept Ms Mulligan experienced shortness of breath and a limitation in her ability to walk more than short distances. That continued for some months. Whilst that was itself a feature of her hypertension, on balance I find the cardiomyopathy played some contributing factor to that and led to a deterioration over those first few months in 2003. She was advised on the potential adverse link between further pregnancy and cardiomyopathy and the strain pregnancy could cause to her heart. The advice at that time also included reference to the likely long-term outcomes. It was that one third of patients got better, one third remained the same and one third could deteriorate. Ms Mulligan describes feeling more tired and exhausted than she did before 2003. This general description of symptomology appears to have an overlap with the sort of tiredness and exhaustion as is attributed to the hypertension which is accepted as a disability. Further Ms Mulligan says she is not sure if it is this alone or combined with other factors.

4.4 In relation to arteriosclerosis, in 2011 Ms Mulligan underwent an ultrasound scan of her carotid arteries. The reports that follow between showed 40-50% blockage of her left internal carotid artery. The plan was to keep it under review. The claimant was already on three different medications and was also prescribed atorvastatin to control cholesterol.

4.5 In December 2015, the blockage was around 50% and completely asymptomatic. Intervention was not advised as the threshold for surgical intervention was 70%. The claimant's medication was reviewed.

4.6 In December 2016 she was again reviewed. The stenosis was the same. A Dr Thapar reported that she had fully recovered from previous myocarditis. Progression of this disease was extremely slow and a review was not planned for another 4 years.

4.7 Ms Mulligan describes the day-to-day effect of arteriosclerosis manifesting in leg pain which affected her ability to walk for long periods. She consulted her GP about this in July

2020 referring to pain after walking for about 1km which required her to rest to ease the pain. It had been noticed for about two years but was more prevalent as she was walking more. She was referred to the vascular department in August 2021 and was reassured that she was already on all the correct medication for arteriosclerosis. Around this time, she also described an effect on her when driving for long car journeys. Her internal carotid artery stenosis, or narrowing, was in the range 40-49%. Her condition was monitored.

4.8 In her evidence to me, Ms Mulligan described sitting, driving or walking for longer than 20 minutes causes pain in her legs. The threshold for when pain sets in has been described in varying measure at times in the evidence. Thereafter, the effect on her ability to carry out day to day activities was on her ability to carry out domestic chores and was put in materially the same way as the effects of the hypertension. In fact, her written evidence in this regard was 'cut and pasted' between paragraphs 8 (hypertension) and 28 (arteriosclerosis).

4.9 On 27 July 2021 Ms Mulligan wrote to her GP in respect of her occupational health consultations and plans to return to work following a period of isolation during covid. That correspondence gave a natural description of her own view of her conditions without thought of the issue now before the tribunal. In it she described her asthma as mild and well controlled and that the cardiomyopathy 'was in the past' and not a current condition. In terms of possible peripheral vascular disease she described her concern about a long wait for a diagnosis or scan but that the pain 'wasn't disabling yet'.

4.10 In December 2021 the claimant's consultant vascular surgeon, Mr Rodriguez, reported on further investigations. He described the CT angiogram showing:-

> ***"minimal disease of the common iliac artery origins. These are less than 50% stenosis when reconstructed using multiplanar reconstruction. These are not thought to be significant. The rest of the vessels look in relatively good shape, although there are some elements of atherosclerosis throughout her arterial tree.***
>
> ***The common iliac artery stenosis are not significant enough to account for the symptoms that she is getting particularly at rest. She does get some long distance claudication at about 30 minutes worth of walking. Again this is difficult to understand with the relatively mild disease burden that she has within the common iliac arteries.***

4.11 I find Mr Rodriguez's clinical conclusion was that arteriosclerosis was not the cause of whatever symptoms Ms Mulligan was experiencing. Whilst she accepts that is the conclusion he reached, she firmly believes he is wrong and it asserts that it is the arteriosclerosis which is causing the symptoms and the consequential effects.

4.12 Mr Rodriguez referred Ms Mulligan for further investigations into potentially differential diagnosis. He recommended MRI of the lumbosacral spine to rule out spinal canal stenosis. That took place and was reported on in March 2022. On this occasion Mr Linnot, a different Consultant Vascular Surgeon described her asymptomatic stenosis remaining at around 50% on the right-hand side and 20-30% on the left, that her referral to him followed her experiencing pain in her thighs reminiscent but not typical of vascular claudication after walking about ½ km. He reported that there was a full complement of peripheral pulses. The CT angiogram showed only mild aortoiliac disease and that the MRI showed reassuringly normal spinal column / cord and no suggestion of any stenosis. A review was planned in two years which takes matters past the relevant period.

4.13 Turning to the impairment of asthma, I find the claimant was diagnosed with asthma in late 2019 following a period of chest infections over the previous 2 years. She described shortness of breath on exertion and sounding wheezy. She underwent chest x-rays. She trialled a steroid inhaler for 6 weeks. On review on 7 November 2019, she was diagnosed with asthma. She explained she was coughing less since taking the Clenil but had hardly needed the Salbutamol. She was reviewed on 15 September 2020. The GP record reports asthma not limiting her activities or disturbing her sleep or ever causing daytime symptoms. She used her broncho dilater infrequently and a maximum of once per day. It says the oral steroids were last used about 6 weeks earlier. Ms Mulligan questions some of the GP record and the accuracy of noting. It is true the same record describes her incorrectly as never having smoked tobacco. On balance, the consistency of the recording in other matters reflecting the minimal effect of the asthma recorded leads me to conclude it is a fair reflection of the consultation and is consistent with other evidence such as the long walks. Ms Mulligan does not put the asthma any more severe than mild suggests to me that that is due to the effect of the medication. I accept as a general proposition that the medication does assist the symptoms and that the effect would be more severe without the medication.

4.14 The next annual review took place on 29 September 2021 with a different clinician. The report is similar and consistent with the previous year, again giving some confidence the record was a fair reflection of the discussions. Asthma was said to be well controlled and there had been no asthma exacerbations in the past year. Ms Mulligan reported shortness of breath at bedtime and on exertion but she did not attribute that to asthma. I find that is more likely than not because it was consistent with the sort of effect she had experienced since long before the asthma diagnosis.

4.15 In her evidence Ms Mulligan says little about the effect of her asthma and what she does say is difficult to isolate between the situation today and that at the material time, and between the actual and deduced effect as they would be without the treatment. She describes her asthma as causing a wheeze/whistle in her chest a lot of the time, that she coughs if she inhales a strong smell such as bleach. She says she gets short of breath when attempting to exercise or walk at a brisk pace. Whilst the existence of shortness of breath on exertion was recorded in the GP notes in September 2021 suggesting it had been present at least for that time, it is somewhat at odds with her long walks which were elsewhere said to be affected by claudication pains. She reported in other contexts keeping herself active and walking more. It is clear she was doing more walking of some extended distances during the relevant period. Nevertheless, I am satisfied that that was in part a result of being able to control the effect of the asthma.

4.16 On that point, it is necessary to consider what evidence there is of the effect without the medication. There is some inconsistency in the evidence on the extent of the use of medication but it is clear that it continued to be prescribed and used throughout the period since the first diagnosis. Ms Mulligan describes the effect of her asthma in terms of how she feels when she misses her Clenil for a day or two, in particular the sensation of getting chest tightness. I accept that evidence. This is the nearest evidence to show the effect without the medication. It is consistent with an early report to her GP when she forgot her inhaler when

away for a weekend and became wheezy again. That in itself is not identifying an adverse effect on the ability to carry out day to day activities. The consequence on the day-to-day activities relied on is said to be that it leaves her very tired requiring the same domestic help as was relied on in respect of the hypertension impairment. That again is difficult to isolate from the impairment that, by the time of the diagnosis of asthma, was already having that same sort of effect on the same day to day activity. On the other hand, I find on balance of probabilities that the presence of the impairment of asthma materially contributes the substantial adverse effect the claimant already encountered in similar symptoms affecting the same day to day activities. There has to have been a deterioration from the pre-asthma period otherwise the claimant would not have known to attend her GP. The level of deterioration must have been significant enough to make her go to the GP. Those factors lead me to find the asthma did materially further restrict her stamina and ability to perform physical tasks. It was another condition she seeks to control with medication and, thankfully, is very effective at doing so.

5. Discussion and Conclusion

Arterioscleoris

5.1 Much of the evidence before me has focused on the medical issues. That may possibly be partly due to the claimant's own medical training and understanding. The difficulty is that the principle focus for a determination under section 6 is not on the clinical diagnoses, but what effect any impairment (whatever its clinical label) may have as impairments on a claimant's ability to carry out normal day to day activities.

5.2 There is no dispute the claimant suffers with a physical impairment of hypertension which amounts to a disability. The respondent does not dispute that the claimant also has a physical impairment of arteriosclerosis. The claimant's case is that she suffers substantial and long-term adverse effects on her ability to carry out normal day to day activities as a result of this impairment as well. In almost every respect, those day-to-day activities are identical to the ones that are relied on, and accepted, as arising from the impairment of hypertension. The one area of very slight difference, is in respect of the walking or driving for extended periods. The respondent does not dispute that the pain she experiences in her muscles arising from what has been described as reminiscent but not typical of claudication (and by definition the effect it has making driving long distances or walking for more than ½ km more difficult) would amount to a substantial adverse effect on her ability to carry out those normal day to day activities. Against that concession, I am also prepared to conclude the period of time over which the claimant has experienced those symptoms means that, by the start of the relevant period, the combination of the time the adverse effect had already lasted, and in any event was likely to continue to last, meant that the 'long term' aspect of the definition was also made out.

5.3 The focus of the dispute is therefore limited to whether the claimant has shown that the adverse effects on her ability to carry out normal day to day activities arose as a result of the impairment explicitly relied on. Is there evidence to form the necessary objective causal connection?

5.4 Putting the question in this way is something I am not entirely comfortable with for reasons I alluded to at the outset. In part, it questions the necessity to argue on this granular basis when the definition under section 6 focuses on the effect on the individual, rather than clinical diagnoses. It also questions the forensic necessity for the argument to arise at all when the claimant herself suggests that the adverse effect on day-to-day activities arising from a disability based on this impairment is almost identical to that arising in the conceded disability based on a different impairment. However, that is how the contention is put and that is how the evidence has been structured.

5.5 The key point in the evidence that determines the essential question of impairment arises from the investigations undertaken by the claimant's vascular surgery department in 2021. Mr Rodriguez's conclusion was that arteriosclerosis was not the cause of the symptoms described and, by extension, any consequential adverse effect on ability to carry out day to day activities.

5.6 Ms Mallin-Martin referred me to the case of *Carl Room Restaurants*. I do not consider it to be establishing any new point of law but it does engage with some general similarities with this case to the extent that a claimant strongly holds a belief is not supported by, or indeed is at odds with, the medical evidence. I adopt the principle that these questions should not be approached as a 'but for' causation point, but require examination as to whether the impairment actually does bring about the effect. The case also dealt with *J v DLA Piper* and *Ministry of Defence v Hay*, both dealing with the situations where the existence of an impairment may be inferred from the fact of its consequential effects. I had anticipated the potential applicability of that approach even before digesting *Carl Room Restaurants.* However, the point made is that such an analysis has within itself a reasoned and evidential basis for the conclusion of the causal link between an impairment and any effect. It does not remove the requirement found in section 6 that an impairment is the cause of the effect that arises.

5.7 The issue in this case is that the claimant has articulated her disability on a very specific and medicalised analysis of her conditions, rather than a more generic approach to impairment. She might equally have referred to a physical impairment in the nature of her cardiovascular system. She has chosen to identify very specific aspects of her cardio-vascular system. Despite that granular approach, the claimant also says I should look at the cardiovascular issues cumulatively although the limited day to day activities affected are basically identical.

5.8 The ultimate question is whether I have a proper evidential basis for concluding that those effects were caused, or materially contributed to, by the specific impairment of arteriosclerosis. The answer is that I do not. The medical evidence is explicitly against that conclusion. The fact that the claimant has a firm belief that her consultant is wrong in that conclusion does not, in this case, help me at all to rationalise the necessary causal link. That is not to say belief is always irrelevant. It could be enough in the right case if, as *Carl Room Restaurants* states, there is an evidential basis for that conclusion. In fact, with a mental impairment, it may go to the very essence of the effect on day-to-day activities. With a physical impairment however, some evidence is needed on which the belief can be founded

which is not the case where the evidence contradicts that belief. The reason for the pain has been clinically explored and a conclusion reached that it is not as a result of this particular physical impairment.

5.9 Taking a step back, the question may be recast on a broader basis as to whether cardio-vascular more generally or cumulatively causes the effect. Again, I have to conclude the answer is still negative. The evidence shows the symptoms have been considered within the field of cardio vascular specialisms and, indeed, the further investigations have explored wider potential impairments, in particular reference to nerve damage potentially arising from an earlier accident. Those further investigations still do not identify this impairment as the cause.

5.10 Finally, I considered whether I can simply infer that there must be some form of impairment. I do not regard that as a legally safe course to take in the circumstances of this case and the medical evidence that has not identified a causal impairment. In any event, to do so would go outside the way the case has been put by legally represented parties. For those reasons I have to conclude the claimant has not established that she is disabled in so far as the impairment of arteriosclerosis causes any adverse effects on her ability to carry out day to day activities.

Cardiomyopathy

5.11 There is again no dispute that the claimant was diagnosed with this physical impairment. The dispute is whether it continued as an impairment into the relevant period for the purposes of this case and, indeed, whether there is any evidence that it had any adverse effect on day-to-day activities.

5.12 I start from the claimant's concession that the physical condition itself has now resolved. The timing to which her concession relates is imprecise but the references in the medical records clearly show that this was resolved many years before the relevant period. In itself, that means the evidence does not support a conclusion that there was, at the relevant time, a physical impairment having the necessary causal effect on her ability to carry out any normal day-to-day activities.

5.13 Beyond that conclusion, the claimant relies on broadly the same effects of tiredness and exhaustion as she attributes to the hypertension. Once again I have asked myself what this argument adds to the mix for either party? For the claimant, she already has established her disability status as having that effect on day-to-day activities. Adding this particular impairment adds nothing. For the respondent, if the effect on day-to-day activities had been put more generally as a physical impairment to the cardio vascular system, the same day to day effects arise as have already been conceded. A disability based on more than one impairment, but contributing to the same adverse effects, does not obviously seem to expand the scope of the liability issues in the claim.

5.14 That aside, it has been difficult to isolate the effects from one impairment to another beyond an analysis based on each having some material and cumulative contribution to the effects. However, if the impairment no longer exists but the effects do, the objective

conclusion has to be that they are no longer caused by that impairment and must be being caused by something else. In this case that would appear to be the ongoing hypertension.

5.15 For that reason, the contention that the claimant was disabled as a result of this impairment at the relevant period also fails.

5.16 However, that is not the end of the assessment. I am satisfied that although the claimant was not disabled by this impairment at the material time, the evidence shows she previously satisfied the definition of someone with a disability in respect of the cardiomyopathy. There clearly was a time when this particular physical impairment materially contributed to a substantial adverse effect on her ability to carry out normal day-to-day activities. In particular, her ability to walk any distance and the effect it had on her ability to perform basic domestic chores. The evidence is not clear to conclude that the duration of that cumulative and material contribution lasted for more than 12 months but it is clear to me that at any time during which it was contributing to the adverse effect, it was "likely" that it would last for at least 12 months or recur. If nothing else, at the time of the diagnosis in July 2003 her prognosis was split into three categories. There was a 1/3rd chance of improvement and 2/3rds chance of things either staying the same or getting worse. That prospect more than satisfies the long-term test in that it 'could well happen" that the substantial adverse effect would last 12 months or recur.

5.17 Moreover, although the underlying impairment is now resolved, there is a sufficient chance that it will spontaneously recur for it to be clinically justified that she continues to take a daily precautionary dose of Losartan. The fact that the focus of potential recurrence is on the underlying impairment, as opposed to the effects of a continuing impairment, means paragraph 2(2) of schedule 1 does not engage and I cannot conclude the statutory definition continues to be made out now or at the relevant period. I am satisfied, however, that the claimant met the statutory definition of disabled in or around 2003 but that that has long since ceased. She therefore enters the relevant period as someone with a past disability, so far as it is necessary or relevant to consider the cardiomyopathy.

Asthma

5.18 There is again no dispute that the claimant has the underlying physical impairment of asthma. The dispute is whether, even taking into account the effect of the medication, it can objectively be said to cause a substantial long term adverse effect on day-to-day activities.

5.19 On one assessment of the evidence, it has been difficult to isolate what effect asthma has had compared to the existing effects of the hypertension. There is a substantial overlap in the claimant's symptoms in the shortness of breath and fatigue and the consequential adverse effects on her ability to carry out normal day to day activities. However, unlike the overlap between hypertension and arteriosclerosis there isn't the same forceful evidence before me which objectively rules out the causal link. Indeed, common sense dictates that asthma will have the sort of impact on shortness and breath, physical activity and tiredness.

5.20 The way this case has been put feels very much like I am being asked to assess whether the asthma in itself causes substantial adverse effect on Ms Mulligan's ability to carry

out normal day to day activities and would have that effect if it were possible to strip out the effect of the pre-existing hypertension. If that is the argument, that is not how I view the section 6 test working. I have to look at the effect on the individual which means having regard to the cumulative effect of any relevant impairments. I am satisfied there is a basis for an objective causal connection between the impairment of asthma and fatigue which leads to the substantial adverse effect on the ability to perform domestic chores. I am satisfied both hypertension and asthma have a cumulative substantial effect although, of course, the circumstances of this case mean that Ms Mulligan established the substantial test by virtue of hypertension alone. Nevertheless, that does not mean that the Asthma does not add to the effect on her abilities in a material way. I am satisfied that from her diagnosis in November 2019 her physical impairments of hypertension and asthma together had a substantial adverse impact on her ability to carry out the normal day to day activities relied on in particular domestic chores. I have not attempted assess the effect of Asthma in theoretical isolation because it does not exist in isolation. Even if it were the case that, stripping out the other impairments, the asthma alone would not meet the statutory definition, that does not prevent the cumulative effect satisfying it. Indeed, two impairments may each individually not meet the test if considered in isolation but their combined effect does. In this case the adverse effects became long term in any event by November 2020 when the cumulative effect of the impairments had lasted 12 months. Insofar as the relevant period starts before that date, in May 2020, I am equally satisfied that at that date the adverse effect was likely to last at least 12 months meaning the prospective test in paragraph 2(1) of schedule 1 was met.

EMPLOYMENT JUDGE R Clark

DATE 29 March 2023